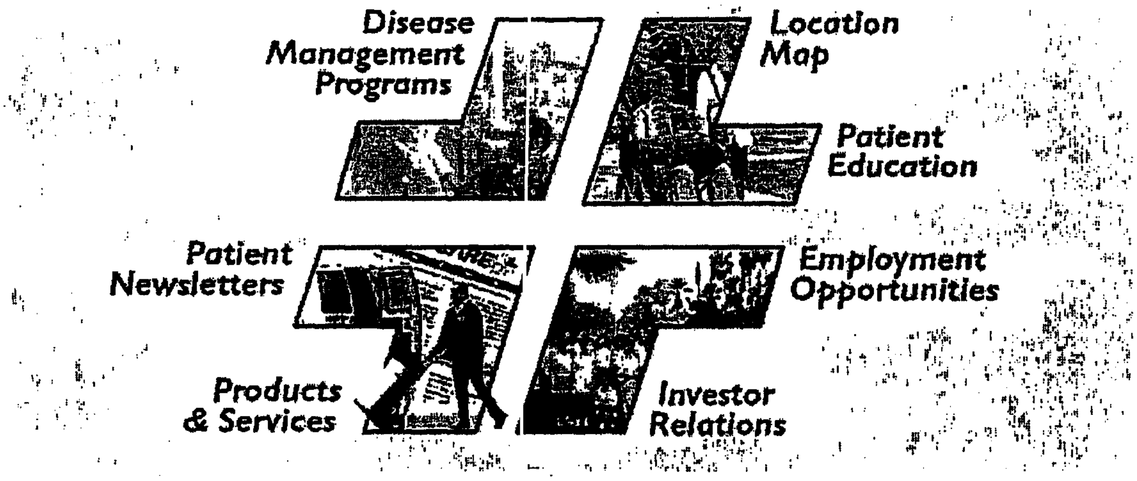
EXHIBIT "A"

LINCARE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Location Map
Patient Education
Patient Newsletters
Employment Opportunities
Products & Services
Investor Relations

CORPORATE VISION

The mission of Lincare is to set standards of excellence for providing respiratory care, infusion therapy and medical equipment to patients in the home. Our company's success, which is characterized by responsiveness and clinical excellence, has been founded on the dedication of our professionals to quality care. Physicians, care givers and patients trust Lincare to provide the quality care they expect and deserve.

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DISEASE MANAGEMENT PROGRAMS

- AIM
- HeartSteps
- Pulmonary Education
- PRO
- Care Check
- Measured Results

Lincare's Disease Management Programs provide physicians with home care protocols and care plans to obtain the best possible patient outcomes. Emphasis is placed on the patient's understanding and compliance with the plan of care to achieve collaborative self-management. Collaborative disease management, which involves the patient, physician and health care provider, yields outcomes of:

- Reduced hospital admissions
- Reduced ER visits
- Improved quality of life and functional ability

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DISEASE MANAGEMENT PROGRAMS

Asthma Intervention & Management (AIM)

Aim is Lincare's education and disease management program for asthma patients. The program is structured around NIH and National Asthma Education Program guidelines, which recommend use of peak flow meters, education, environmental controls, and medications, including anti-inflammatory agents. AIM consists of individualized educational sessions, concentrating on peak flow zone management and enhanced patient compliance. The program includes the AIM kit, therapist follow-up, and physician reports. The program is expected to reduce lost work days and school days, improve quality of life, and save 25% in the overall cost of disease management.

Pulmonary Education

Lincare's home-based pulmonary education program provides individualized education and support to clinically stable respiratory patients and their families. Teaching includes relaxation techniques, coughing and breathing exercises, support literature, videos, discharge assessment, maintenance and physician follow-up reports. Outcomes include enhanced patient compliance with the treatment plan, reduction in hospital readmissions and emergency room visits, improved coping strategies, and improved quality of life.

Positive Respiratory Outcomes (PRO)

PRO, the Lincare COPD

Management
Program, provides physicians with complete homecare protocols for treating each stage of chronic obstructive pulmonary disease and obtaining the best possible outcomes for each stage through collaborative disease management. Patients are encouraged to understand their plan of care and become an active participant in it. Regular follow-up maximizes compliance and provides measurable outcomes, which include decreased incidence of hospital and ER visits, improved functional ability, improved quality of life, and less unscheduled physician time.

The HeartSteps Program

HeartSteps, a multidisciplinary tool designed to assist patients and physicians in the effective management of congestive heart failure, is composed of three modules, including Functional Assessment. It is designed to increase intervals between hospital admissions for patients with CHF and improve patient's self-management of CHF.

Heart steps
A Guide to Living with CHF

Objectives of Lincare's HeartSteps program include:

1. Increased intervals between hospital admissions for patients with CHF.
2. Provide appropriate assessment of patients functional level and exercise needs.
3. Improve patient compliance.
4. Increase patients self-management of CHF.
5. Improve quality of life for CHF patients.

Care Check

Lincare's Care Check program is a clinical service designed to meet the needs of early stage COPD patients. The components of the program include:

1. Home visits by licensed Clinical Specialists
2. Respiratory Assessment with screening Oximetry
3. Education on disease

process, prescribed
therapies and equipment management
4. Follow-up reporting

The benefits of Lincare's Care Check program include improved patient compliance through patient education, clinical feedback in a timely manner and improved quality of life for our COPD patients.

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CUSTOMERS & VISITORS

- Location Map
- Travel Assistance Tips
- Lincare Comments on CMS Proposed Rule on Dispensing Fee for Inhalation Drugs

Customers and Visitors

The links below will take you to information that we think will be of interest to you as a patient or visitor.

- Location Map
- Travel Assistance Tips
- Lincare Comments on CMS Proposed Rule on Dispensing Fee for Inhalation Drugs

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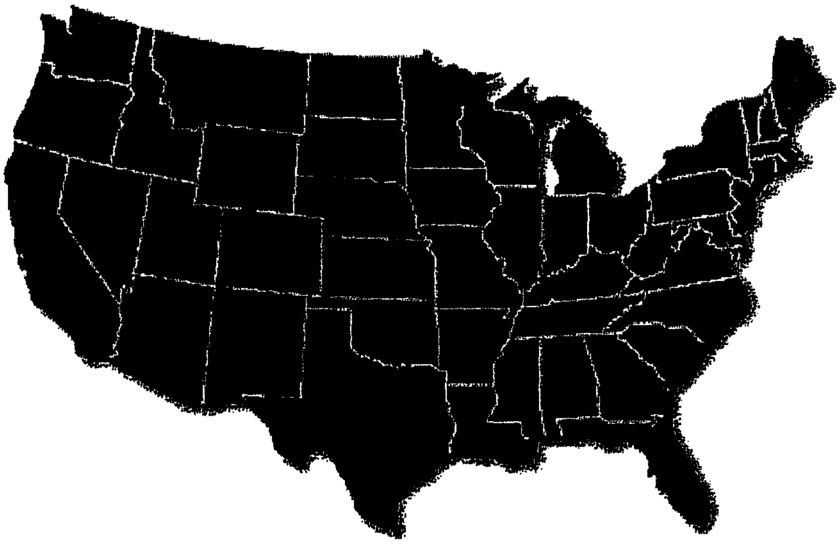
CUSTOMERS & VISITORS

Location Map

- Location Map
- Travel Assistance Tips

Click on a state for locations, or use the list below.



Alabama	Arizona	Arkansas	California
Colorado	Connecticut	Florida	Georgia
Idaho	Illinois	Indiana	Iowa
Kansas	Kentucky	Louisiana	Maine
Maryland	Massachusetts	Michigan	Minnesota
Mississippi	Missouri	Montana	Nebraska
Nevada	New Hampshire	New Jersey	New Mexico
New York	North Carolina	North Dakota	Ohio
Oklahoma	Oregon	Pennsylvania	Rhode Island
South Carolina	South Dakota	Tennessee	Texas
Utah	Vermont	Virginia	Washington
West Virginia	Wisconsin	Wyoming	

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Location Map at Lincare

CUSTOMERS & VISITORS

Travel Assistance Tips

Mobility - a very important kind of freedom for almost everyone, but especially for the COPD (Chronic Obstructive Pulmonary Disease) patient. The therapeutic benefit that is now made possible is the main reason for having LINCARE Portable System. With the mobility this system provides, many COPD patients can go freely about their daily routine, take long trips, but most importantly can medically benefit from the prescribed exercise that the Oxygen Portable permits.

It must always be understood that carrying oxygen equipment in vehicles presents some problems and potential hazards. You can travel safely with liquid oxygen units, however you must do it properly.

In preparing to travel, two of the most important considerations are: how long can you personally travel between Portable refills; and how can refills be accomplished?

An important point to remember: you must think of all ventures in terms of your personal time between refills. Once you determine your own travel range, you can apply this to your intended means of travel to plan your trip.

Advance planning is the key to the success of your trip whether you plan to use public transportation, personal auto, camper or motor home. Each mode of transportation requires slightly different arrangements, but all require careful planning to ensure you are always able to renew your oxygen supply.

It is essential that you and your local LINCARE center work out the time you can safely expect to travel between Portable refills. This time will depend on your prescribed flow rate and should also include a 25 percent safety margin to allow for unforeseen delays during travel.

The Portable alone will typically supply a patient's needs for

4 to 8 hours. If your travel will take longer, some means of Portable refill must be arranged.

This is where the staff of your local LINCARE center comes in. They can make arrangements to have your oxygen supply requirements met by an Oxygen Portable supplier at your destination. If your travel plan is flexible or you wish to make arrangements yourself, a nationwide Oxygen Portable Service Directory is available from LINCARE.

If you are going to an area with a vastly different altitude, your prescription may need to be adjusted for this change. *Consult your doctor on this point specifically.*

Before you attempt to take your oxygen system out of your home and onto the road, please read this booklet carefully, then talk over your plans with your physician or therapist and your LINCARE center; they can help make your travels easier and safer.

Planning Checklist:

1. Check with your doctor.
2. Read and understand the safety precautions required for traveling with Oxygen Portable equipment.
3. Check with your insurance company (be prepared to pay for refills and equipment with cash, and submit your insurance claim when you return home.)
4. Check with the Oxygen Portable dealers where you will be getting refills. A Service Directory provided by your LINCARE center with help here.

Safety Considerations

The safety precautions required for traveling with Oxygen Portable equipment include those which are covered in the Instruction Literature for your specific units. These instructions should be read and understood by all members of your traveling party. They are available from your LINCARE center.

Rules for Handling and Transporting Liquid Oxygen Units

Your LINCARE Service Representative can help you prepare to transport these units. If you attempt to move the unit yourself, it is absolutely essential that you observe the following safety rules.

Keep the unit upright at all times. Do not store in the trunk of a car. Laying a Portable or Reservoir on its side will cause rapid release of oxygen through the unit's pressure relief valve. This results in very high oxygen concentrations near the unit and greatly increases the chance of fire. Slight tipping of the larger units during loading and unloading from a vehicle is not dangerous. This booklet will suggest proper methods to use to secure each unit during transit.

Disconnect therapy equipment before handling/transporting Liquid Oxygen System. Remove all flowmeter or humidifier equipment and cap the outlet fitting before attempting to move these units. If oxygen equipment is dropped or knocked over when these accessories are in place, they could be broken off, causing rapid release of oxygen. This could result in possible personal injury or damage to property.

Maintain adequate ventilation. All liquid oxygen containers release small amounts of gas periodically. Use, storage, or filling of oxygen equipment in a confined area could enrich the area with more oxygen than normal. Oxygen enriched air doesn't burn by itself, but it does cause fire to burn much more rapidly than normal. For this reason, adequate ventilation must always be provided as a precaution against fire. In the interior of a car for example, the air may become enriched if all the windows are closed. When using oxygen in a car, always keep a window partially open regardless of the weather.

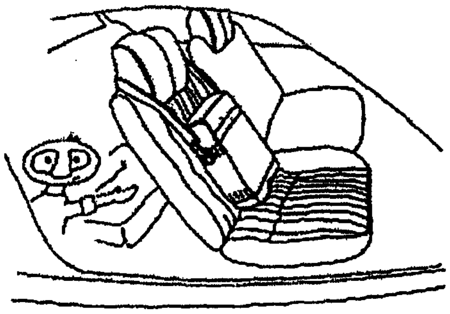
There is one instance when more oxygen than normal is released from an Oxygen Portable unit: The process of filling a Portable from a reservoir will release more oxygen than any other operation. Remove all oxygen containers from your vehicle to an open, well-ventilated area before filling.

Warning Others. In all modes of travel you will be in contact with people who may not understand the safety precautions necessary when using oxygen equipment. Do not hesitate to inform those around you. No Smoking signs are available from your LINCARE center for the purpose of warning others when oxygen is in use.

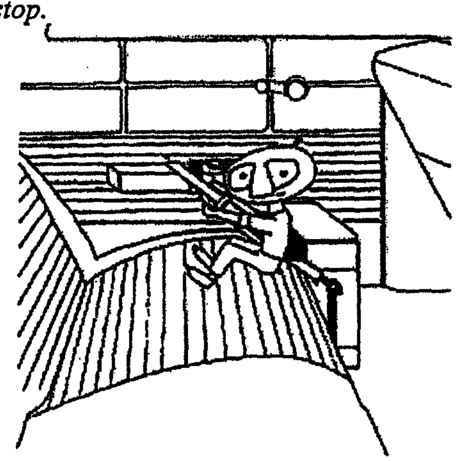
Using Portable Oxygen when Traveling by Private Vehicle

Short trips by auto. When you travel with the Portable you must secure your Portable unit in the vehicle to keep it upright.

The carrying strap and the auto seat belt may be convenient aids in fastening the Portable unit. The following illustration shows a suggested method of using the carrying strap to attach the Portable to a bucket-type seat of a passenger car. In this instance the unit must be equipped with additional cannula tubing to allow you freedom of movement within the vehicle while the Portable is in one place.



Another method that may be used to secure the Portable is to loop the carrying strap around the headrest of a bench-type seat. As the illustration below suggests, it may be positioned on the floor in the rear seat area and secured by looping the carrying strap through the arm rest. Here again additional cannula tubing will be required. *The important thing is to secure the Portable so that it cannot tip in case of a sudden stop.*



It may be that none of these methods is practical in your automobile. If this is the case, contact your LINCARE center for advice as to the best way to secure the Portable.

Anytime that filled oxygen equipment is inside an automobile, a window must be left open. Although newer cars have some form of flow-thru ventilation, the amount depends on the type and model of car. So, roll a window down at least part-way to be certain the interior of your vehicle does not become oxygen enriched.

Longer trips. There may be times when you would like to travel for a longer period of time than a single filling of the Oxygen Portable will allow. Such activities might include anything from an overnight visit to nearby relatives, to an extended vacation far from home. The thought is probably, "How can I take the Reservoir along so I will have plenty of oxygen?"

Up to this point we have discussed carrying only the Portable in a private automobile. This is for a very good reason - few automobiles are large enough to safely carry a filled reservoir. This unit must not be stored in the trunk and must be kept upright at all times.

Your LINCARE center can offer alternatives to transporting your own unit. If your destination is nearby, LINCARE might arrange to move your reservoir or deliver another unit so that it will be waiting for you when you arrive. For longer trips, LINCARE can provide a national directory of all suppliers of your Oxygen System which will permit you to make arrangements for resupply when out of your immediate area.

Campers & Motor Homes. If you plan to travel by camper or motor home, the large interior space of these vehicles may allow a reservoir to be secured to a permanent part of the vehicle. Select a location near a door or window where ventilation is best. Be careful not to confine the unit in any small space. For a reservoir, the location near a door is important so that the door may be opened to provide extra ventilation during a Portable filling operation. A window or overhead camper vent must always be left open while filled equipment is inside.

Many camper vehicles introduce potential hazards that are different from those found in your home. Gas heat or cooking appliances that use an open flame are two examples. Be aware that these changes from your normal surroundings do exist and check for these hazards before using such appliances in a vehicle where oxygen is present. Check out the installation of your oxygen equipment with your LINCARE center prior to use.

Some tips to remember in relation to use of the Reservoir while traveling include:

- Use a Rotary Flow Control Valve for setting your unit's output. Flowmeter accuracy is affected by the motion of a vehicle, while the rotary flow control is not. This makes the Rotary Flow Control Valve a better choice for travel.
- Try to minimize the handling of a filled Reservoir.

With the weight of oxygen inside, these units are more sensitive to handling damage or shock.

Use of the Portable on Public Transportation

Making arrangements for travel on public transportation with oxygen equipment may be difficult. You may be asking a ticket agent or reservation clerk to provide services that he/she is unfamiliar with. If you encounter difficulty ask to speak to a supervisor or someone of higher authority. Be persistent! Remain courteous and explain your situation carefully.

In all types of public transportation the carrying of filled Reservoir must be considered impractical. Trips must be carefully planned to provide Portable refills at stopover points where, by pre-arrangement, an oxygen supplier can provide your oxygen needs.

Rail Travel

The Amtrak railway passenger system is making progress toward removing barriers from intercity train travel to give everyone access to this mode of travel. A booklet entitled "ACCESS AMTRAK" is available free of charge from Amtrak. This booklet does not deal specifically with travel while using oxygen, but it does contain other helpful information concerning travel for handicapped passengers.

Amtrak has no hesitancy in allowing patients on board Amtrak trains with their Oxygen Portable equipment in either coach or sleeping car accommodations.

Amtrak requests that a patient planning to travel with Oxygen equipment make them aware of the situation in advance so that they may assist in any way they can to make a trip more comfortable and enjoyable. To alert Amtrak, tell the reservations clerk or travel agent.

The call you make to the reservation number is the key to a successful trip. Here you can find out exactly what Amtrak has to offer and what problems you can expect to encounter. In addition, it permits Amtrak to make any special arrangements which might be required.

When talking to the reservations clerk be sure to cover the following points:

- Describe your need to carry oxygen and your origin and destination points.
- Explain that scheduling is critical to you.
- Ask which kind of accommodations you will need, on the basis of your particular needs.
- If assistance is necessary, ask if stations are attended by Amtrak personnel and if they will be available to help you. Your travel request will be referred to a special service desk to find answers to your questions and that desk will coordinate your trip from beginning to end with Amtrak personnel. You should receive a call confirming your travel arrangements. If you do not, follow up the inquiry and confirm the arrangements yourself before your departure date.

Whether you are making a short trip or a long trip, it is best to call Amtrak a reasonable time before your trip to ensure that special accommodations can be arranged. Although most short-distance trains are unreserved, handicapped travelers may be granted a reserved seat by prearrangement.

Bus Travel

Travel by bus may be the least clearly defined of public transportation means. For local travel, check with your bus operator for regulations. If travel with oxygen is allowed, take the necessary steps to inform people around you that smoking may be a hazard. Most public vehicles now have a "No Smoking" section; insist on being seated there.

Under Department of Transportation regulations, bus operators may permit travel with oxygen equipment. Some operators, however, may be concerned if you show up with oxygen equipment without prior notice.

Check with your bus service in advance to prevent problems.

In this mode of travel, as in any other, planning is the key. Here again, it will not be possible to carry a filled Reservoir with you. Arrangements must be made to resupply you with oxygen at your destination.

General Air Travel

The use of Oxygen Portable equipment aboard commercial aircraft is not permitted. However, many airlines are prepared to provide oxygen for you while you are on board their aircraft. The policies of the various air carriers on providing supplemental oxygen service are not all alike. Virtually all airlines do require at least 24 hour advance notice and levy a charge for the oxygen service.

Typical airline requirements are:

1. Advance Notice: 24 hours to one week before boarding.
2. Prescription Required: quantity of oxygen and flow rate; most require flow rate adjusted for cabin pressure used by that airline.
3. Doctor's Release Required: should include diagnosis and release with approval for air travel; special forms may be necessary. Be sure to have several copies of completed forms with you.
4. Service Charges: typically $40 per flight; connecting flights usually involve charges for each ticket coupon. Some charge by number of cylinders used.
5. Some airlines require patient to be accompanied by friend or relative.
6. Most airlines permit carrying of **empty** personal oxygen equipment as baggage, some do not.

Be sure to check with the airline to verify their policies on each of these points. If the reservations operator or ticket agent cannot answer your questions, be patient and remember that such questions probably are not routine business. Ask for the telephone number of the airline's "Air Medical Department" or "Special Services" usually located at the airline's home office.

In addition to arranging for oxygen service aboard the aircraft, you will also need to arrange for supplying your oxygen needs before flight time, during any layover for connecting flights, and after arrival at your destination. Your LINCARE center can assist you with these details and may be able to meet you at the airport gate with a portable unit and also set up a reservoir at your lodging.

The following tips may be helpful:

- Discuss your travel plans with your physician. A prescription with the flow rate adjusted for cabin altitude will probably be required by the airline. A doctor's release and approval for air travel is generally needed. Take along several copies to be sure that you have enough for all flights and for the oxygen supplier at your destination.
- Your LINCARE center's staff can help you arrange for your oxygen supply at your destination. Ask for a copy of the "Oxygen Portable Service Directory," which lists dealer locations in the continental United States and Hawaii. Confirmed advance arrangements with the

dealer at your destination are essential.

- If you plan to take your Oxygen Portable with you on the plane as baggage, confirm that the airline will accept it. If airport personnel are reluctant to accept the Portable as checked baggage, assure them that it is empty and use the contents indicator to demonstrate.
- Airlines can usually provide assistance if needed for boarding and deplaning passengers. Wheelchairs and golf carts at large airports can be requested when reservations are made.
- Travel with a companion. In most airports, the pace and the distances between ticket counters and boarding gates may be considerable. If problems develop, someone who knows your needs can be of great help.
- You may want to bring a cannula with you, as well as adapters and connectors.

Be at the airline at least 2 hours early because you must pay for the oxygen at the ticket counter at the time of the flight. There is usually a line and the transaction takes about 20 minutes to process. You will board the plane early.

Take all your prescription drugs on board with you.

Turn on the oxygen, relax and enjoy.

Remember, patience and thorough attention to detail are your most important assets in making the arrangements for air travel. Plan carefully, confirm all arrangements well in advance, and then enjoy your trip.

Specific Airline Requirement Links

American Airlines www.aa.com (general) Travel Assistance	Alaska Airlines www.AlaskaAir.com
American West www.AmericaWest.com Special Needs American West does not accept compressed gasses or passenger regulated oxygen	Delta Airlines www.delta.com Special Needs
Hawiian Air www.hawaiianair.com	Horizon Air www.horizonair.com Horizon Air does not allow Oxygen on any flights
Northwest Air	South West Airlines

www.nwa.com Special Needs	www.southwest.com South West does not allow Oxygen on any flights
United Airlines www.ual.com	US Airways www.usairways.com Special Needs

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VIA Overnight Mail

September 28, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments Submitted Regarding Proposed Rule Entitled: Medicare Program Revisions to Payment Policies Under the Physician Fee Schedule (FY 2006).

Section: Inhalation Drugs and Dispensing Fee

File Code CMS-1502-P

Dear Administrator McClellan:

Lincare Holdings Inc. ("Lincare") is writing to submit comments to Proposed Rule CMS-1502-P, "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006" (the "Proposed Rule"). Unless otherwise indicated, our comments are directed at those provisions of the Proposed Rule affecting payment for respiratory medications administered through a nebulizer ("inhalation drugs") and the corresponding dispensing fee.

Lincare is one of the nation's largest providers of home respiratory equipment and related services to patients in the home setting. Our customers typically suffer from chronic obstructive pulmonary disease, commonly referred to as COPD, such as emphysema, chronic bronchitis or asthma, and require supplemental oxygen, inhalation drugs or other respiratory therapy services in order to alleviate the symptoms of respiratory disease. We currently serve over 600,000 customers throughout the United States through nearly 900 local operating centers and 22 respiratory and infusion pharmacies.

In short, we believe that CMS has an obligation to ensure that the dispensing fee paid to inhalation drug suppliers, including Lincare, adequately covers the necessary costs of supplying inhalation drugs to Medicare beneficiaries. We believe that the dispensing fees established for the 2005 calendar year do not cover the full range of costs incurred by inhalation drug suppliers and, while the changes to a number of longstanding Medicare shipping policies have provided new options to beneficiaries and the inhalation drug suppliers that serve them, these policies have not reduced suppliers' costs. Indeed, with the pending increase in fuel costs generally, and more recently stemming from the devastation caused by Hurricane Katrina and Rita, Lincare expects transportation and other related costs that depend upon transportation to *increase* in 2006.

While the Proposed Rule predicts that the coverage of metered dose inhalers under the Part D Program will shift a number of beneficiaries away from traditional nebulizer-based medications, there is simply no data available at the present time to support this assertion with an as-of-yet untested Part D program. At a minimum, until additional data is collected by CMS with regard to the conversion of beneficiaries' longstanding medication needs, Lincare believes it is unwise to gamble with Medicare beneficiaries' care by adjusting downward the dispensing fee paid to inhalation pharmacy suppliers.

A more detailed summary of our comments follows below.

Background on COPD and Treatments for this Disease

COPD is the fourth leading cause of death in the United States, following heart disease, cancer and stroke. COPD affects approximately 16 million people, causing significant morbidity from time of onset. Furthermore, it is the only major chronic disease currently increasing in prevalence and mortality. Financially, COPD patients engender a total estimated annual health care cost of more then $40 billion in the United States alone. Sixty percent of these costs are related to direct medical expenditures (hospital services, emergency department visits, primary care visits, and medication) with the balance being indirect costs associated with morbidity and premature death. Of the total direct medical costs, pharmaceuticals average approximately 10% ($2.3 billion). Respiratory conditions are attributed with the most frequent reason for hospitalizations, accounting for an estimated 17% of all occurrences.

Inhaled bronchodilators (such as albuterol and ipratropium) are the cornerstone of pharmacological therapy for patients with COPD. The proper use of these respiratory medications can decrease airway resistance and dynamic hyperinflation of the lungs, thereby alleviating the most disabling symptom of COPD, dypsnea, or shortness of breath. Reduction of dypsnea in COPD is the primary goal of respiratory medication therapy, and prudent use of respiratory medications can serve to improve the long-term outcome of the disease in a manner that is both cost effective and minimizes adverse effects.

Costs Incurred by Inhalation Drug Suppliers

First and foremost, we are writing to provide CMS with information on the various services that inhalation drug suppliers currently furnish Medicare beneficiaries and the associated costs of these services. In addition, we are writing to address whether any of the services being provided by inhalation drug suppliers may be covered through another part of the Medicare program, such as the physician fee schedule or the DME benefit.

To that end, specialty inhalation drug suppliers such as Lincare incur a myriad of costs that should be considered by CMS when establishing or adjusting the dispensing fee to be paid. Inhalation drug suppliers are not typical "retail" or big box pharmacy stores. While some inhalation drugs are relatively common (e.g., albuterol sulfate), other inhalation drugs must be compounded by the supplier based upon specific physician orders. Also, inhalation drug suppliers, such as Lincare, maintain professional staff including pharmacists and respiratory therapists to provide telephonic or in-person patient education and consultative services.

Services furnished by suppliers of inhalation drugs fall within seven broad categories. Those categories, and the percentage of Lincare's total costs of dispensing inhalation drugs associated with each category, are as follows: 1.) Patient Intake (17.8% of costs); 2.) Compounding, Dispensing and Pharmacy Assessment (19.0%); 3.) Delivery, Set-up and Patient Education (27.3%); 4.) Follow-up and Compliance Monitoring (11.6%); 5.) Quality Assurance, Accreditation, Licensing and Regulatory Compliance (11.0%); 6.) Medicare Billing and Compliance Requirements (9.1%); and 7.) Other Direct and Indirect Costs and Expenses (4.2%). Functionally, the majority of these costs are associated with salaries and related expenses of professional employees, including pharmacists, pharmacy technicians and respiratory therapists, non-professional customer service, support and administrative staff, facility and related expenses (centralized pharmacies and local branch locations), freight and other delivery charges, and business infrastructure costs necessary to operate as a pharmacy and support high quality patient care (MIS and communication systems, licensing and regulatory compliance, accreditation, professional liability insurance).

A more detailed summary of the components of these seven broad categories are set forth below:

Patient Intake

Local service center
•Receipt of patient demographics from ordering physicians
•Receipt of medical information from ordering physicians, including qualifying diagnoses
•Notification of central pharmacy re: medication order
•Verification of patient demographic information
•Verification of beneficiary Medicare coverage and secondary insurer information
•Verification of patient caregiver and/or next of kin information
•Establishment of patient health record in computerized MIS
•Patient assessment by respiratory therapist of clinical condition and assessment of home environment
Pharmacy
•Receipt of verbal or written order for inhalation medications
•Physician contacted to confirm medication order
•Independent database searched to verify physician UPIN number
•Patient pharmacy profile established in computerized MIS

Compounding, Dispensing and Pharmacy Assessment

Compounding
•Specialized facilities (separate from drug storage and dispensing area) and equipment required for de novo pharmacy compounding operations
•Validation and regular review of the compounding process to assure sterility and potency to beyond-use-date of the compounded inhalation medication
•Sterility and dose potency testing of compounded doses
•Specialized training and testing of pharmacists and pharmacy technicians
•Staff competency evaluation and testing
•Environmental monitoring and testing
Dispensing
•Verification of patient demographic information
•Prescription review and verification, including qualifying diagnosis for the ordered medication, dose size and strength, daily dosing frequency ("SIG") and length of therapy
•Preparation of dispensing label
•Counting and packaging unit doses of medication
•Pharmacist final verification prior to dispensing (correct patient, drug, dose, frequency (SIG), route of administration)
•Pharmacist verification and "wet ink" initialing of prescription label
Pharmacy assessment
•Obtaining information on other medications that the patient may be self-administering
•Assurance that inhalation medications are compatible with other drugs the patient is taking
•Determining other diagnoses and co-morbidities that the patient may be subject to
•Assuring that the inhalation medications are not contraindicated for those secondary diagnoses
•Making patient aware that pharmacy consulting services are available
•Providing a secure, physical space in the pharmacy for "walk in" consulting upon patient request
•Assessing side effects from the prescribed medication

Delivery, Set-up and Patient Education

Delivery
•Packaging and handling of medications for delivery
•Coordinating express and ground delivery services
•Delivery costs: third-party express and ground delivery services, including fuel surcharges
•Obtaining and documenting proof of delivery
•Arrangements for first-dose medication services

Set-up
•Completion of patient documentation including medical information release forms, HIPAA instruction and compliance forms, certification of patient and/or caregiver training and instruction
•After hours/on-call technical and clinical support
Patient education
•Instruction of patient and/or caregiver on implementation of drug treatment regimen, anticipated therapeutic outcome and potential side-effects
•Instruction of patient and/or caregiver on proper infection control in the home, safe handling and storage of medications, and emergency preparedness
•After hours/on-call capabilities for home visits for patient set-up, education or troubleshooting

Follow-up and Compliance Monitoring

Follow-up
•Assessment of patient's retained knowledge of equipment use and purpose of therapy, safety and infection control procedures
•Handling of changes in patient circumstances, including beneficiary change of address, disconnected telephone, change of secondary insurer, illness requiring hospitalization
•Handling and processing changes in physician orders and new prescriptions
•Identifying through patient interaction changes in clinical conditions and reporting same to treating physician
•Providing periodic feedback to the physician on patient compliance and progress
Compliance Monitoring
•Monthly call to verify patient's ongoing medical status and determine if any changes have occurred in medical condition and/or other medication regimen
•Verification of number of doses consumed since last dispensing and number of doses remaining
•In-home visits to patients as required or as established in plan of care

Quality Assurance, Accreditation, Licensing and Regulatory Compliance

Quality Assurance
•Employee training and periodic validation of competency
•Periodic validation of all service delivery documentation and record keeping systems
•Compliant investigation and resolution
•Compliance monitoring and auditing of company service and support systems
•Customer satisfaction evaluation and follow-up
•Facility and operating equipment maintenance
•Process improvement programs
•Medical waste management and removal
Accreditation
•Accreditation agency oversight and compliance
•Demonstration of adherence to pharmacy operations, compounding guidelines promulgated by the United States Pharmacopoeia
Licensing
•Separate pharmacy licensing and renewal for all states into which inhalation medications are dispensed
•Separate pharmacist licensing and renewal for certain states into which medications are dispensed, as required by state pharmacy regulations
•Special local water and sewage disposal licensing and permitting
•DME distributor licensing

Medicare Billing and Compliance

•Collection and verification of all required documentation
(Verbal and written order documentation, patient demographic and insurance information, physician demographics and license information, delivery tickets and proof of delivery, proof of initial and ongoing

medical necessity, medical information releases, proof of receipt of information privacy notices, proper HCPCS coding of all items dispensed and delivered)
•Invoice preparation and claim submission to Medicare, secondary insurer and the patient (co-payment and/or deductible)
•Computer systems for electronic batching and transmission of invoices
•Personal financial assessment in the event waiver of co-payment is requested or required
•Collection follow-up procedures
•Posting of payments to individual patient accounts
•After appropriate appeals and collection efforts, write off of unpaid bills as bad debt

Other Direct and Indirect Costs and Expenses

•Corporate oversight of quality and regulatory systems
•Employee benefits management
•Professional and business liability insurance
•Management information and records management systems
•Communications and networking expenses
•Facility and equipment operating costs, rent, repairs and maintenance
•Mileage/fuel reimbursement for field staff making home visits

At Lincare, we provide these services to facilitate a high level of patient care and, importantly, to manage a patient's COPD or other related illness. At Lincare, and other similarly situated inhalation drug suppliers, we are not merely filling and dispensing drugs to a patient. At Lincare, we offer critical components of the total respiratory services required by patients which go far beyond mere drug dispensing.

We would note that CMS is bound to make payment for Medicare covered items and services in a manner that approximates the costs of the supplier's furnishing of such items and services or be comparable to charges of similarly situated suppliers. Specifically, Section 1842(b)(3) of the Act requires that CMS pay a reasonable cost or charge for any item or service covered under Part B of the Medicare Program. While no "specific" statutory formula has been established regarding the "dispensing fee" calculation, the general statutory payment provisions which mandate that Medicare payments for Part B items and services be "reasonable" should be considered by CMS when calculating a dispensing fee paid to licensed pharmacies furnishing inhalation drugs.

CMS' regulations implementing the statutory mandate of Section 1842(b)(3) also make clear that Medicare must pay a reasonable charge for any covered Medicare Part B item or service and clarify that the Act affords CMS flexibility in determining what is reasonable. See, 42 C.F.R. § 405.500 et. seq. Specifically, the regulations provide that "the law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for." 42 C.F.R. § 405.502(a). The regulations include certain criteria to assist CMS in determining reasonable charges.

CMS has a longstanding history of recognizing services as "related to patient care" and reimbursing providers for these services. Accordingly, CMS should consider all reasonable costs when establishing the costs of the dispensing fee to be paid to inhalation pharmacies that furnish inhalation drugs. Reimbursable patient costs can and should include, among other things, patient set-up, delivery, pharmacy staff, patient refill and related compliance activities, regulatory compliance and risk management, patient/caregiver education and training, facility costs, billing, quality assurance and drug utilization review, and accreditation and licensing activities.

Lincare further believes that the agency has failed to undertake any meaningful study of the costs associated with inhalation drug dispensing services in direct contrast to its prior commitment to the industry. Of note, the final 2005 Physician Fee Schedule expressly states that CMS is "continuing to study these services and associated cost categories as the new payment systems are implemented and we gain experience with them. We intend to revisit this issue and proceed through notice and comment rulemaking in order to establish an appropriate dispensing fee for 2006." 66 Fed. Reg. 66236, 66339 (November 15, 2004). To our knowledge, and notwithstanding the agency's express commitment to study this issue before establishing a dispensing fee in 2006, it has not done so. Instead, the Proposed Rule suggests, without a single published agency study to date that the fee is too high and simply requests that the industry supply CMS with data by September 30, 2005.

We believe that the agency has failed to fulfill its prior commitment to the industry to study this issue in depth and, more importantly, has shirked its APA notice and comment rulemaking obligations to collect meaningful data for a service that could have adverse consequences to Medicare beneficiaries. We strongly encourage CMS to collect and publish the available data in a subsequent rulemaking notice, giving all interested parties an opportunity to comment on the data before establishing a final dispensing number for 2006. This is the standard rulemaking process that CMS follows for other all other Part B RVU adjustments as well as the process employed by CMS throughout the entire Part A program.

As CMS is aware, in October, 2004, CMS released a copy of its letter to the Department of Health and Human Services commenting on a draft report by the Government Accountability Office (GAO) entitled "Medicare: Appropriate Dispensing Fee Needed for Suppliers of Inhalation Therapy Drugs." CMS noted the extreme variation that the GAO found in the costs of dispensing inhalation drugs to Medicare beneficiaries. GAO found that 2003 per patient monthly costs of dispensing these medications ranged from a low of $7 to a high of $204.

Further, CMS has considered an industry-sponsored study prepared by Muse & Associates entitled, "The Costs of Delivering Inhalation Drug Services to Medicare Beneficiaries." The Muse study was based on a survey of 109 pharmacies representing 2,448 branch locations and providing services to 337,348 Medicare beneficiaries (estimated by Muse to represent 61% of all Medicare inhalation drug therapy patients in the first quarter of 2004). The Muse study concluded that a dispensing fee of $68.10 would be necessary to maintain existing levels of service to Medicare beneficiaries and provide an average operating margin of 7% to inhalation drug pharmacies. Muse also estimated that a $68.10 dispensing fee, in combination with federally-mandated reductions in Medicare payment amounts for inhalation drugs, would result in $4.0 billion to $7.0 billion in program savings over a 10-year period. After reviewing the information from the GAO survey, the Muse study and other comments, CMS indicated that it believed that $55.00 to $64.00 per month is a reasonable range for a 2005 dispensing fee. CMS ultimately set the dispensing fee at $57.00 in its 2005 final rule, CMS-1429-FC.

In short, the only studies that have been conducted (both GAO and industry supplied) more than support the current dispensing fee established in 2005 and, further, both suggest that there is ample data to support a *higher*, not *lower*, dispensing fee in 2006.

Of significance, Lincare estimates that the combined drug payment reductions will produce $10.5 billion of federal budget savings over 10 years, in contrast to the initial CBO estimates of only $4.2 billion. Accordingly, Lincare believes that the payment reductions will have a far greater adverse impact on DMEPOS suppliers than predicted by CBO or CMS—further warranting extreme caution when considering any modifications to the dispensing fee to be paid to DMEPOS suppliers. Since CMS now is approaching one years' worth of claims data under the new ASP + 6% drug payment methodology, Lincare respectfully requests that CMS re-examine the total impact of the inhalation drug cuts in comparison to original estimates and, further, that this study be performed before adjusting the dispensing fee.

Inhalation pharmacy supplier costs have not gone down in 2005, as CMS appears to suggest in its Proposed Rule. To the contrary, inhalation pharmacy suppliers have seen their dispensing costs rise in the past year, as increases in gasoline prices have adversely affected shipping costs through higher fuel surcharges by common carriers and pharmacy wage inflation has added to direct labor costs. Muse & Associates issued a memorandum to the American Association for Homecare in May, 2005, presenting a method for calculating a justifiable annual update in the dispensing fee for home respiratory services. Muse proposes the creation of a Market Basket Index (MBI) that reflects the year-to-year cost increases associated with providing dispensing services to patients. Muse constructed a customized index based on government published inflation statistics for a compilation of goods and services applied to actual industry data. Using this approach, Muse estimates that costs to provide services covered by the dispensing fee increased by

3.2% from calendar year 2003 to calendar year 2004 and suggests that this percentage be used as the increase from 2005 to 2006 as in other areas of the Medicare program that use the MBI approach for annual updates. This would result in a 2006 dispensing fee of ***$58.82, an increase of $1.82 over the current fee level.*** As a point of reference, CMS notes in the Proposed Rule that the percent change in the CPI for medical care for the 12-month period ending June 2004 was 5.1%.

We also point out that the devastation in the Gulf States as a result of Hurricanes Katrina and Rita have significantly impacted business throughout America that depend upon interstate transport to move goods, services and people back and forth. Among others, UPS has notified customers of an increase in fuel surcharge caps to 12.5% effective October 3, 2005, which when implemented will push up the average delivery cost per package by an additional 4% over increases already established for 2005. In the past year, the IRS has increased the deduction for mileage reimbursement for business travel from $0.375 to $0.405, an increase of 8%, and has implemented an additional 20% increase to $0.485 per mile through the end of this year, reflecting the heavy burden of rising fuel costs on businesses. Likewise, the increase in fuel costs is widely noted as the "straw that broke the camels back" for both Delta Airlines and Northwestern Airlines—both of whom have filed for bankruptcy. While the full economic impact of Hurricanes Katrina and Rita may not be known for some time, we believe it is inappropriate at this point in time for CMS to further reduce payments to inhalation drug suppliers.

Lincare also reminds CMS that it is expected to implement additional quality standards pursuant to Section 302(a) of the Medicare Modernization Act of 2003 (MMA) which requires that the Secretary develop and implement such standards that will be applied by a recognized independent accreditation organization. CMS has just recently published for comment the proposed supplier quality guidelines pursuant to public rulemaking. The 104-page document sets forth proposed supplier business quality standards and supplier product-specific service requirements. We understand that CMS has indicated that these new quality standards will be implemented as early as April of 2006, which will further impact the costs incurred by all DMEPOS suppliers, including inhalation drug suppliers.

Lastly, we note that CMS seeks input regarding whether any of these additional services are reimbursed through any other code (or combination of codes). While the supplier standards (42 C.F.R. 424.57(c)) require that inhalation pharmacies provide these services, CMS does not, to our knowledge, separately reimburse pharmacy monitoring and compliance, delivery or quality assurance of any of the services listed above. Lincare, like other high quality inhalation suppliers, provides these services to facilitate the provision of medical care for patients with complex medical needs. Given that drugs are reimbursed at ASP + 6%, the dispensing fee is effectively the only way in which these important services will be captured and reimbursed.

In short, at a time where costs of inhalation drug suppliers are *increasing* due to a combination of unforeseen natural disasters, general increases in the CPI, and new regulatory requirements imposed by Congress, Lincare strongly opposes any efforts to decrease the current dispensing fee paid to inhalation drug suppliers. In our view, as reflected in the data listed above, we believe the current 2005 dispensing fee is too low and does not adequately cover the costs incurred by a specialty inhalation drug supplier.[1]

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1 [redacted]

Impact on 90-Day Supply Provisions

For calendar year 2005, CMS introduced a 90-day supply option for dispensing inhalation drugs—the Proposed Rule seeks comments on the impact of this new option. The 90-day supply schedule has not been widely chosen by Medicare beneficiaries or their prescribing physicians due to a number of clinical, practical and economic considerations. Monthly shipments foster more frequent patient contact and correspond better with patient compliance protocols. Frequent contact with the patient provides opportunities for ongoing education regarding their lung disease and the importance of adhering to the physician prescribed drug regimen to produce a positive health outcome. Even with frequent contact, prescription compliance is challenging among our patients, with compliance rates, as measured by monthly reorders, of approximately 50% for all active patients and 74% for long-term patients on therapy for more than a year.

In addition, there is reluctance on the part of patients to receive a 90-day supply of drugs at one time, not only due to the sheer number of medication vials that need to be stored and refrigerated, but for economic reasons as patients receive larger, quarterly invoices for co-payments due in the month of shipment as opposed to a more manageable monthly payment cycle. As CMS is well aware, many seniors are on a fixed and sometimes limited budget. While 90-day drug supply arrangements are prevalent in the private sector, patients are frequently encouraged to use such programs for maintenance medications by reduced and/or waived copayments offered by the applicable commercial payor. Medicare does not offer such a discount and, indeed, waiver of any coinsurance amounts otherwise due a provider or supplier may subject that provider to fines or penalties.

Provision of 90-day drug supplies also work better for maintenance medications with a stable and managed medical condition such as certain types of heart disease (e.g., cholesterol medications) and/or diabetes. In the COPD population, patient prescriptions (type of drug, dosage, frequency of administration) often change within a 90-day period due to side effects, dosage efficacy or other factors. These changes can occur frequently at the start of therapy as the physician adjusts treatment in accordance with the patient's pulmonary response to the therapy. Additional changes occur over time due to the progressive nature of chronic lung disease, as the patient's lung capacity diminishes.

Our experience with inhalation drug therapy patients indicates an average of 5.1 prescription changes in the initial year of drug therapy, with 32% of active patients with one to three prescription changes and 68% with four or more changes per year. Shipping on a 90-day supply schedule would likely result in an excessive supply of unused medications. Additionally, patients may terminate therapy due to death or other circumstances within a 90-day period with unused supplies of drugs on hand. CMS has not addressed how a supplier should handle drugs not used by beneficiaries who may die before running out of drugs and, at least in other areas of the Part B program, suppliers have been found at fault for items and supplies not used by beneficiaries prior to the date of death.

Lastly, the 90-day dispensing fee established in 2005 is inadequate to cover the costs of dispensing a 90-day supply. In our view, CMS' presumption that a 90-day drug quantity significantly reduces a supplier's costs is flawed. In 2005, CMS established a dispensing fee amount of $80.00 for a 90-day supply in

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[redacted]

comparison to a $57.00 fee for a 30-day supply. Supplying larger dose quantities with less frequency would reduce certain variable costs associated with providing inhalation drug therapy, primarily in the areas of freight costs (modestly offset by larger package size and weight) and opportunities for certain staff reductions due to lower dispensing volumes and less frequent claim submission; however, a majority of the fixed costs remain the same. At a minimum, we estimate that the 90-day dispensing fee should be approximately $130 in order to encourage pharmacies to shift to a 90-day supply. However, even at that fee, we believe that the clinical and practical considerations of shifting to a 90-day supply would limit the adoption of the practice by inhalation drug suppliers for the reasons outlined above.

Revised Time Frame for Delivery Refills

CMS seeks information on how revised guidelines regarding the time frame for delivery of refills has affected the need for overnight delivery services and the extent to which suppliers have shifted their shipping to ground services. Our mix of ground and express shipments has changed only slightly in 2005 versus a year ago. In calendar year 2004, we shipped 58.2% of our volume overnight or express and 41.8% ground. This year, our overnight and express shipments account for 57.7% of volume, with ground comprising 42.3%. One of the challenges with moving more volume to ground is the irregular ordering patterns of many patients. Many patients simply wait until they are out (or virtually out) of medication before authorizing a refill, precipitating the need for overnight delivery. Medicare rules require that the DMEPOS pharmacy not allow more than a 30-day supply of drugs on hand (assuming a 30-day supply schedule). While CMS has attempted to mitigate the impact of this by allowing shipments to occur on the 25th day of a 30-day shipment cycle thereby allowing overlapping claims for drug payments, we have experienced numerous problems with claims processing by the DMERCs for the associated dispensing fee (HCPCS code G0371). The DMERC claim processing systems were set up to process G0371 as "one unit per 30-day period." We have received tens of thousands of dispensing fee claim denials as a result, with DMERC systems unable to reconcile dispensing fees that may occur within 25 to 29 days of each other. While Lincare is pursuing an adjustment of these claims through the appeal processes, this has resulted in additional costs being incurred by Lincare personnel, considerable frustration when dealing with the DMERCs and, most importantly, a significant delay in receiving proper payment. While we are aware that CMS has instructed the DMERCs to rectify this claims processing problem, we have not seen a complete resolution of the issue.

Impact of Metered Dose Inhalers Under Part D

The Proposed Rule appears to suggest that the availability of metered dose inhalers (MDIs) under Medicare Part D will impact the need for traditional inhalation drugs furnished in connection with nebulizer devices which are currently covered under Part B. We disagree with this presumption. Over the past decade, MDIs have become the first line of therapy for the vast majority of patients with airway disease. Most clinicians with whom we work agree that nebulizers are prescribed for administering bronchodilator medications to patients with severe disease at risk for hospitalization and those incapable of using MDIs for a variety of reasons, including inadequate manual dexterity, poor inspiratory effort and mental impairment. In considering this particular aspect of respiratory medication delivery, there can be no doubt that a certain percentage of the patient population does and always will have difficulty performing effective MDI technique. For this portion of the population, of which the elderly Medicare beneficiary is likely to be a significant component, available medical literature may even suggest a contraindication for MDI delivery. It is our belief that the vast majority of physicians are aware of the potential difficulties of MDI delivery and do exercise appropriate judgment on a patient-by-patient basis. Once the need for inhalation therapy is established, the choice of delivery system should, and for all practical purposes does, reside exclusively with the prescribing physician.

Importantly, the push to "switch" beneficiaries from nebulizer-based medications to MDIs may have a significant adverse financial impact on such beneficiaries. By our estimates, beneficiary out of pocket costs in 2006 for MDIs covered under Medicare Part D *will substantially exceed the costs* for inhalation drugs already covered under Part B. Consider the following analysis of projected annual costs for a standard MDI regimen under Medicare Part D for the most commonly prescribed respiratory medications:

MDI	Annual Drug Costs (*)	Patient Deductible	Patient Co-Payment	Part D Premium	Total Patient Cost/Yr
Combivent	$1,828.71	$250.00	$394.68	$386.40	$1,031.08
Generic Albuterol	$83.65	$83.65	$0.00	$386.40	$470.05
Proventil	$496.73	$250.00	$61.68	$386.40	$698.08
Atrovent	$1,656.83	$250.00	$351.71	$386.40	$988.11
Advair 250/50	$1,521.29	$250.00	$317.82	$386.40	$954.22

(*) derived from sample of mail order pricing for retail pharmacies in Florida, New York and California markets as published on www.medicare.gov website under Medicare-Approved Drug Discount Cards

(**) Part D Assumptions:
Monthly premium of $32.20
Yearly deductible of $250.00
25% coinsurance up to $2,250
100% coinsurance up to $3,600
5% coinsurance beyond $3,600

Beneficiaries under Part B Medicare enjoy the benefit of coverage for inhalation drugs delivered via a nebulizer. The annual patient out-of-pocket costs for a standard regimen of inhalation drug therapy ranges between $273.30 and $586.06, including co-payments and annual patient deductibles. In the absence of other considerations, Medicare beneficiaries will experience a *financial loss* in most instances if they were to abandon inhalation drug therapy under Part B in favor of MDI therapy under Part D. In addition, with the announcement by the FDA that MDIs using chlorofluorocarbon (CFC) propellants must no longer be produced, marketed or sold in the United States after December 31, 2008, it is expected that new CFC-free MDIs may be more expensive than the CFC-containing products they replace. In short, MDIs are not a fungible substitute for traditional inhalation medications and, indeed, beneficiaries' costs and consequently, the Medicare Program's costs, may actually increase with the availability of MDIs under Part D.

Conclusion

As CMS is well aware, the availability of inhalation medications to patients in the home setting is met by a relatively small number of niche pharmacies that are able to meet the unique distribution and patient care needs of these Medicare beneficiaries. Changes in reimbursement for inhalation drugs, first taking effect in 2004 with a reduction in the AWP-based payment rates for inhalation drugs, and in 2005 with the implementation of the ASP-based reimbursement system with dispensing fee, have had a *significant economic impact on Lincare* and other home respiratory therapy providers. We have witnessed both local and national inhalation pharmacies withdraw from the provision of inhalation drug therapy and expect continued consolidation in the market.

At Lincare alone, we estimate that there was a *$54 million reduction* to our revenues in 2004 and project an additional reduction of approximately *$140 million in 2005* as a result of these reimbursement changes. Lincare has worked hard to preserve a consistent level of high quality care for the home respiratory patient. Over the past year, we have found ways to become more efficient in the delivery of care to our patients through process improvements, improved productivity and, where possible, modest staff reductions. We remain concerned that CMS continues to discount the nature and type of services that an inhalation pharmacy supplier offers to Medicare beneficiaries. We are concerned that CMS' apparent efforts to reduce the dispensing fee to some arbitrary amount, perhaps as suggested by a national chain drug store (in comments submitted over a year ago, prior to the implementation of the ASP reimbursement system, and which may have been misconstrued), would significantly disrupt access to these inhalation drugs by Medicare patients suffering from COPD and other pulmonary diseases. Certainly, this was not the intent of Congress in passing legislation in 2003 to expand coverage for prescription drugs for Medicare beneficiaries.

Lincare wishes to thank CMS for the opportunity to comment on the Proposed Rule. We support CMS in its efforts to validate the payment mechanism for inhalation drugs and recognize that balancing the fiscal realities of the Medicare program against maintaining quality health care and access to needed drugs are the primary objectives of sound administration of the program. We believe that access to these critical medications and related therapies can only be preserved by maintaining the current $57.00 dispensing fee and, indeed, we believe that the data actually supports an *increase* rather than a *decrease* to the current dispensing fee. We encourage CMS to carefully consider the data submitted by all suppliers and, if necessary, to propose a supplemental rulemaking that will outline the process to collect this data and/or we encourage CMS to engage appropriate experts to fully and finally evaluate the necessary services and costs associated with the dispensing of inhalation drugs to Medicare beneficiaries.

Respectfully submitted,

/Paul G. Gabos/

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Patient Information

In keeping with our commitment to respiratory patients and their physicians, Lincare provides a unique home-based pulmonary rehabilitation program individualized to the patient and family. Physicians are kept informed as their patients progress toward increased independence and ability to perform self-care activities, improved psychosocial coping skills, and enhanced compliance with prescribed therapies.

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Breathing Exercises

1. Pursed Lip Breathing

You have probably noticed when shortness of breath occurs to an athlete during periods of exercise, they tend to blow the air out of their mouths by puffing out their cheeks. You may have done this as well when you've exerted yourself. This is a normal response to shortness of breath, and it provides for a quick and easy way to improve breathing patterns.

What Does It Do?

- Improves ventilation
- Decreases air trapping in the lungs
- Decreases the work of breathing
- Improves breathing patterns
- Causes general relaxation How?
- Prolongs exhalation—slows down the breathing rate
- Causes a slight back pressure in the lungs that keeps the airways open longer
- Improves the movement of old air out of the lungs and allows for more new air to get into the lungs Procedure

REMEMBER—Exhalation must be 3-4 times longer than inhalation, so do not force the air out.

1. Sit down but sit up straight, relaxed
2. Breath in, preferably through the nose
3. Purse lips slightly (as if to whistle)
4. Breath out slowly through pursed lips
5. Do not force the air out

Practice this procedure 4-5 times a day initially to get the correct breathing pattern. You should utilize pursed lip breathing when you are experiencing shortness of breath either at rest or with exertion, or if you feel nervous or apprehensive.

IMPORTANT—You may experience a lightheaded feeling while doing pursed lip breathing. This indicates that you are over ventilating yourself and you should breathe more slowly.

2. Diaphragm Breathing

The most efficient breathing muscle is the diaphragm. Many people with COPD no longer use this important breathing muscle effectively. This exercise is designed to help you better utilize this muscle in the act of breathing.

IMPORTANT—You will notice an increased effort will be needed to utilize this muscle correctly. You will notice, at first, that you'll get tired while doing this exercise. Keep at it, for in a short time you'll begin to notice that it will require less effort to breathe, and you'll be rewarded by being able to do it with less effort.

- Strengthens the diaphragm
- Coordinates diaphragm movement when breathing
- Less effort required to breathe
- Less energy utilized for breathing

How?

- Correctly utilizes the most effective muscle for breathing In the beginning, practice this procedure for 5-10 minutes, 3-4 times a day.

You can gradually increase the length of your exercise period and perhaps the effort required by placing a book on the abdomen.

After you feel comfortable with this procedure, practice while sitting in a chair or while standing.

Procedure

1. Lie on your back in a bed with your knees bent.
2. Place one of your hands on your abdomen.
3. Place your other hand on your upper chest.
4. As you inhale through your nose, make your stomach move out and keep your upper chest as still as possible.
5. As you exhale through pursed lips, let your stomach fall inward. Your hand on the upper chest must remain as still as possible during the entire procedure.

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Walking Exercises

Remember

- If you have oxygen, check with your physician about the correct amount to use when you're walking.
- Do not attempt to walk and talk while beginning your exercise program.
- Inhale through your nose and exhale through pursed lips.
- Exhale at least twice as long as you inhale. Don't force the air out during exhalation.

Walking

1. Start with short walks. Your breathing muscles and your walking muscles need to get into shape.
2. Use "rhythmic breathing". Count the number of steps you take while inhaling and double the number of steps for exhalation. Example: 2 steps -- inhale, 4 step -- exhale. Do not change the rhythm from inhalation to exhalation.
3. With practice you may find that a 3 to 1 rhythm is more comfortable than 2 to 1. Use the rhythm that is most comfortable for you.
4. Gradually increase your walking distance as you get stronger. Try to add a little more distance every week. Don't overextend yourself.
5. Set reasonable goals. Plan rest stops. Don't allow yourself to get over tired
6. During inclement weather, or times of the year when you're most uncomfortable, you can get your exercise in climate controlled areas like shopping malls or in a more formal environment like a hospital's rehabilitation area.
7. Remember, go slow, don't rush, get stronger and most of all, enjoy yourself.

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Coughing Exercises

Hydration

Thick , sticky mucus is difficult to cough up, especially with a weakened cough reflex. It is important that you drink enough fluids to keep your mucus thin and loose. Check with your physician to determine how much fluid you should drink daily to keep your cough effective.

Humidify your home or at least the room you sleep in and the room you spend most of your time in. Keep your humidifier clean as they are a possible source of infection.

Do not smoke as smoking takes moisture out of your mucus and makes the mucus thicker.

Cough

Remember, control your coughing as uncontrolled coughing can make you short of breath. Discuss with your physician which type of coughing exercise is best for you.

You should perform these coughing maneuvers whenever you feel the need to cough or as instructed by your physician. A good controlled cough is especially helpful when you first get up in the morning and about an hour before bedtime. Have a cup of coffee or tea first (or other drink recommended by your physician) and relax.

Sit up straight in a chair when attempting these coughing exercises. Have a tissue handy.

Exercise A

1. Sit up straight on a hard-backed, stable chair, relax.
2. Take in 2-3 deep breaths through your nose and exhale slowly through pursed lips.
3. Fold your arms across your abdomen.
4. Take in a comfortable deep breath through your nose.
5. Lean forward, pressing your arms against your

abdomen and cough while leaning forward.
6. Relax, rest 5-10 minutes.
7. Perform again if needed.

Exercise B

1. Sit up straight, relax.
2. Take in 2-3 deep breaths through your nose and exhale slowly through pursed lips.
3. Take in a moderately deep breath, hold breath, expel air while saying H or K once.
4. When you feel comfortable with this exercise try and say the H or K 3-4 times while exhaling.

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